MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12942

CERTIFICATE OF DEATH

12951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PATUXENT RIVER
c. LENGTH OF STAY IN 1b: 22 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): STATION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
d. STREET ADDRESS: RT #1, BOX 154
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALICIA — Middle ANN — Last ANDERSON

4. DATE OF DEATH: Month SEPT — Day 18 — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: CAUC

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: AUG 26, 1967

9. AGE (In years lost birthday): _ yrs. — IF UNDER 1 YEAR: Months — Days 24 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): ST. MARY'S MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES A. ANDERSON

14. MOTHER'S MAIDEN NAME: Emily Lorine Caughorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MOTHER — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): VOMITING WITH DEHYDRATION — 36 HOURS
DUE TO (c): MENINGOMYELOCOELE — BIRTH TO 18 SEP 67
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
751X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 17 SEP, 19 67, to 18 SEP, 19 67, that (I) (we) last saw the deceased alive on 18 SEP 19 67, and that death occurred at 0305 M, from causes and on the date stated above.

22a. SIGNATURE: James R Abel — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): James R. ABEL

22d. ADDRESS: Same as #1.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9/21/67

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.

23d. LOCATION (City or Town) (County) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR: John M. Welch — **ADDRESS**: JOHN M. WELCH - LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE SEP 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1-21592

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14443

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): VALLEY LEE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): VALLEY LEE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BARBARA Middle ANN Last DAILEY
4. DATE OF DEATH: Month SEPTEMBER Day 30, Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: COLORED
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 18, 1967
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months 6 Days 12 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: EUGENE DAILEY
14. MOTHER'S MAIDEN NAME: MARY CATHERINE GREENWEEL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: FATHER Address: SAME AS # 2 ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (SDII)
DUE TO
(b)
DUE TO
(c)
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd MD M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): WILLIAM D. BOYD M. D.
Address (Street, city, town, or county):
22. DATE SIGNED: OCTOBER 1, 67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT. 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: BETHESDA CEMETERY
23d. LOCATION (City or Town) (County) (State): VALLEY LEE, ST. MARY'S, MD.
24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY
ADDRESS: LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: OCT 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

7-21524

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12944

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12952

1. PLACE OF DEATH
a. COUNTY: St. Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Mechanicsville
d. STREET ADDRESS: Rt.2 Golden Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

18-1

3. NAME OF DECEASED (Type or print): First Charles Middle LeRoy Lost Dooley

4. DATE OF DEATH: Month September Doy 13. Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov.27,1906
9. AGE (In yeors lost birthdoy): 60 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civia Service
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (Stote or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert L. Dooley
14. MOTHER'S MAIDEN NAME: Stella C. Bostic

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO. 578-10-8407
17. INFORMANT: Helen V. Dooley (Wife) Address: 3712- Andover Place S Washington,DC.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cardiac arrythmia — INTERVAL BETWEEN ONSET AND DEATH: Immed
DUE TO
(b): arteriosclerotic H D — 2 years
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm Boyd M.D.
EXAMINER'S NAME (Type): William D. Boyd M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 9/13/67

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept.16,1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (Stote): Suitland, Maryland

24. FUNERAL DIRECTOR ADDRESS: Simmons Bros. Simmons Bros.-1661-Gd. Hope RD. SE. Wash.,DC

25o. REC'D BY REGISTRAR DATE: SEP 15 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12945 — 12953

1. **PLACE OF DEATH**
   a. COUNTY: ST. MARY'S — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
   c. LENGTH OF STAY IN 1b:

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park
   d. STREET ADDRESS: 259 Chinlee Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Air Station Hospital

3. **NAME OF DECEASED** (Type or print): First: MELVIN — Middle: C. — Last: DUNCAN

4. **DATE OF DEATH**: Month: September — Day: 8, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 7/24/1939

9. AGE (In years last birthday): 28 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): YEOMAN

10b. KIND OF BUSINESS OR INDUSTRY: US NAVY

11. BIRTHPLACE (State or foreign country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES W. THOMPSON

14. MOTHER'S MAIDEN NAME: ROBERTHA MEADERDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): SEP'56 SEP'67

16. SOCIAL SECURITY NO.: 338 30 8770

17. INFORMANT — Address: OFFICIAL NAVY RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia due to hanging
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
974 X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hanged self

20c. TIME OF INJURY Month, Day, Year: 1:50 Hour a.m. xxxx 9-8 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Lexington Park St.Mary's

21. I **certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: September 8, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANSIT

23b. DATE THEREOF: 9/13/67

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City or Town) (County) (State): OAKLAND, CALIF.

24. FUNERAL DIRECTOR — ADDRESS: John M. Welch — JOHN M. WELCH - LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12946

CERTIFICATE OF DEATH

12954

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Valley Lee
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Andover Estates

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Valley Lee
d. STREET ADDRESS: Andover Estate
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: Tom — Last: Giddings

4. DATE OF DEATH: Month: September — Day: 13, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 9, 1901

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tom Giddings

14. MOTHER'S MAIDEN NAME: Sarah Ann Giddings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 219-12-3466

17. INFORMANT: Louie Elizabeth Giddings — Address: SAME AS # 2 ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 Minutes
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Feb- , 1967, to Sept 13 1967, that (I) (~~we~~) last saw the deceased alive on Sept. 13 1967, and that death occurred at 12 ~~P.M.~~ A.M. from causes and on the date stated above.

22a. SIGNATURE: W.H. Patrick — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-14-67

22c. PHYSICIAN'S NAME (Type): William H. Patrick M. D.

22d. ADDRESS: Lexington Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. George Episcopal

23d. LOCATION (City or Town) (County) (State): Valley Lee, St. Mary's, Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any defect is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12947

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12955

1. **PLACE OF DEATH**
   a. COUNTY: St. Mary's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXXXXXXXXXXXX LEONARDTOWN
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: ST. MARY'S
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
   d. STREET ADDRESS: Leonardtown, Maryland
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First CHARLES — Middle A. — Last HEBB

4. **DATE OF DEATH**: Month Sept. — Day 9 — Year 1967

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 5/23/1947

9. AGE (In years last birthday): 20 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Ignatius Hebb

14. MOTHER'S MAIDEN NAME: Florance Louise Barber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
    (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles I. Hebb — Address: Leonardtown

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Multiple traumatic injuries
    DUE TO (b):
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
    INTERVAL BETWEEN ONSET AND DEATH:

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Subject was struck by auto

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: 4:30 p.m. 9 9 1967

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) Loveville (County) St. Mary's (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: R. S. Fisher M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

Address (Street, city, town, or county):

22. DATE SIGNED: September 10, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: ST. ALOYSIUS

23d. LOCATION (City or Town) (County) (State): LEONARDTOWN, ST. MARY'S, MD.

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY — ADDRESS: LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR: DATE SEP 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12948

CERTIFICATE OF DEATH

12956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then pleose remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotion, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: St. Mary's
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Patuxent River
c. LENGTH OF STAY IN 1b: 1½ hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Air Station Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Lexington Park
d. STREET ADDRESS: Rt 1 Box 37
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: ; Lost: Ivancik
4. DATE OF DEATH: Month: September; Day: 14; Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 4, 1886
9. AGE (In years lost birthday): 81 yrs.
IF UNDER 1 YEAR: Months ; Days
IF UNDER 24 HRS: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Cabinet Marer
11. BIRTHPLACE (County & State, or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Ivancik
14. MOTHER'S MAIDEN NAME: Magdalene Faccate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John R. Ivancik; Address: Same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Heart failure
DUE TO (b): Arteriosclerosis, coronary thromb.
DUE TO (c): Senility
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying couse last.
4201
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from June, 1967, to Sept., 1967, that (I) (we) last saw the deceased alive an Sept 8 1967, and that death accurred at 6:30 PM, from causes and an the date stated abave.

22a. SIGNATURE: Michael Barbarich
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9.15.67
22c. PHYSICIAN'S NAME (Type): Michael Barbarich M. D.
22d. ADDRESS: Leonardtown, Md ~~Lexington Park, Maryland~~

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Holy Face Cemetery
23d. LOCATION (City or Town) (County) (State): Great Mills, St. Mary's, Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley
ADDRESS: Leonardtown, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12949

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12957

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patuxent River
d. STREET ADDRESS: Box 222
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle F. — Last IVERY, SR

4. DATE OF DEATH: Month September — Day 13, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11/26/1901

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: AUTO PARTS(SALES)

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN H. IVERY

14. MOTHER'S MAIDEN NAME: MARY JANE BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 167 03 3771

17. INFORMANT: JOHN F. IVERY JR. — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
4221
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 9/14/67

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANSIT
23b. DATE THEREOF: 9/14/67
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (State): BEAVER , PENNA.

24. FUNERAL DIRECTOR: John M. Welch
ADDRESS: JOHN M. WELCH - LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: SEP 18 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

12950

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12958

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NAS, Patuxent River
c. LENGTH OF STAY IN 1b: 11 hrs. 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Station Hospital, USNAS, Patuxent River

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park
d. STREET ADDRESS: 33 E. Rennell Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

18-1

26

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Joseph — Last: Lupi

4. DATE OF DEATH: Month: September — Day: 5, — Year: 1967

5. SEX: male

6. COLOR OR RACE: caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: September 5, 1967

9. AGE (In years last birthday): ___ yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours 11 Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not applicable

10b. KIND OF BUSINESS OR INDUSTRY: Not applicable

11. BIRTHPLACE (County & State, or foreign country): St. Mary's, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Sebastian Anthony Lupi

14. MOTHER'S MAIDEN NAME: Sandra Lee Nemeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NA
(If yes give war or dates of service): NA

16. SOCIAL SECURITY NO.: NA

17. INFORMANT Address: Official U. S. Navy Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyaline membrane disease
DUE TO
(b): Prematurity
DUE TO
(c):

7735

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 11hrs.20Min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 5 19 67, to Sept. 5, 1967, that (I) (we) last saw the deceased alive on Sept. 5, 19 67, and that death occurred at 3:15P M, from causes and on the date stated above.

22a. SIGNATURE: James R. Abel M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: September 5, 1967

22c. PHYSICIAN'S NAME (Type): JAMES R. ABEL, LT, MC, USN

22d. ADDRESS: USNAS, Patuxent River, Md. 20670

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANSIT

23b. DATE THEREOF: 9/7/67

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City or Town) (County) (State): EASTON, PENNA.

24. FUNERAL DIRECTOR: John W. Welch

ADDRESS: JOHN W. WELCH - LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE SEP 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

7-250500

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12951 Item 7 Film C393 9/28/67 kk

CERTIFICATE OF DEATH

12959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PATUXENT RIVER NAVAL AIR STATION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
d. STREET ADDRESS: RT 1 Box 145 B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANKLIN Middle EMERY Last McBEE

4. DATE OF DEATH: Month SEPTEMBER Day 21, Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 29, 1895

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAPER MILL

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM McBEE

14. MOTHER'S MAIDEN NAME: MARY CATHERINE BROWNFIELD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: NORMAN PHILLIPS Address: SAME AS # 2 ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of prostate
DUE TO (b): with metastases to
DUE TO (c): congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 66, 19 to Sept 24, 19 67, that (I) (we) last saw the deceased alive on Sept 24 19 67, and that death occurred at 11:10 M, from causes and on the date stated above.

22a. SIGNATURE: Juanito Roa MD
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): JUANITO ROA M. D.

22d. ADDRESS: LEXINGTON PARK, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 25, 1967

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

23d. LOCATION (City or Town) (County) (State): COVINGTON, VIRGINIA

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY ADDRESS: LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 25 1967

25b. REGISTRAR'S SIGNATURE:

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12952 12960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 47 Minutes
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural California, Md.
d. STREET ADDRESS: Box 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Moses
4. DATE OF DEATH: Month: September — Day: 16 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 16, 1967
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 47

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael A. Moses
14. MOTHER'S MAIDEN NAME: Mary Reeves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mother — Address: Box 2 California, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fetal apnea
7620
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 47 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized anasarca

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 16, 1967, to Sept 16, 1967, that (I) (we) last saw the deceased alive on Sept 16 1967, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Leon W Berube — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-16-67
22c. PHYSICIAN'S NAME (Type): Leon Berube, M.D.
22d. ADDRESS: Mechanicsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-18-67
23c. NAME OF CEMETERY OR CREMATORY: All Saints
23d. LOCATION (City, town or county) (State): Oakley, Md.

24. FUNERAL DIRECTOR: W. C. Mattingley — ADDRESS: Leonardtown, Md.
25a. REC'D BY REGISTRAR DATE: SEP 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

7-263003

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12953 12961

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ST. MARY,S MARYLAND — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): LEONARDTOWN MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY,S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
d. STREET ADDRESS: LEONARDTOWN Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEILA Middle: CATHERINE Last: NORRIS

4. DATE OF DEATH: Month: SEPTEMBER Day: 28 Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 2/11/1877

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (County & State, or foreign country): ST, MARY,S MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN T. YATES

14. MOTHER'S MAIDEN NAME: LUCY M. CLARKE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: 212-56-0154J1

17. INFORMANT Address: J. RICHARD NORRIS LEONARDTOWN Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
4221
DUE TO
(b): Cardio Vascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/1/60 to Sept 28, 1967 that (I) (we) last saw the deceased alive on Sept 27 1967, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Charles Greenwell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/29/67

22c. PHYSICIAN'S NAME (Type): CHARLES GREENWELL M.D.

22d. ADDRESS: LEONARDTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9/30/1967

23c. NAME OF CEMETERY OR CREMATORY: ST. ALOYSIUS

23d. LOCATION (City, town or county) (State): LEONARDTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Welch

ADDRESS: JOHN M. WELCH LEONARDTOWN Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (1)
20M S-63

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (4)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12962

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Lexington Park
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 227 Chinlee Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Lexington Park
d. STREET ADDRESS: 227 Chinlee Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RICHARD — Middle M. — Lost OWEN

4. DATE OF DEATH: Month September — Doy 8 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/15/67

9. AGE (In yeors lost birthday): 2½ mo. yrs.
IF UNDER 1 YEAR: Months 2½ — Doys — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (Stote or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard H. Owen

14. MOTHER'S MAIDEN NAME: Sharon Weller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MOTHER — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): SDII
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R S Fisher M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

Address (Street, city, town, or county):

22. DATE SIGNED: September 8, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: JOY CHAPEL CEMETERY

23d. LOCATION (City or Town) (County) (State): HOLLYWOOD, MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: W. CLARKE MATTINGLEY — LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

7-262835

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12955 — 12963

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: St. Mary's MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: St. Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown c. LENGTH OF STAY IN 1b: 15 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Leonardtown, 18.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): St. Mary's Hospital	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Doy	Year
John	Henry	Price	September	11	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Doys	IF UNDER 24 HRS.: Hours / Min.
Male	Nergo	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Sept. 1, 1880	87 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Cyria Brown	Ellen Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Annie Florine Price Leonardtown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac failure

DUE TO (b): Cardio Vascular disease

DUE TO (c):

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.

4221

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/15, 1963, to Sept 11, 1967, that (I) (we) last saw the deceased alive on Sept 11th 1967, and that death occurred at 10 P M, from causes and on the date stoted above.

22a. SIGNATURE	M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22b. DATE SIGNED
Charles Greenwell		

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Charles Greenwell M. D.	Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 14, 1967	St. Aloysius Cemetery	Leonardtown, St. Mary's, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. Clarke Mattingley Leonardtown, Maryland	SEP 14 1967	Charles Jugger

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12956 — 12964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ST. MARY,S
a. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY,S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY,S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CALLAWAY MARYLAND
d. STREET ADDRESS: CALLAWAY MARYLAND
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN Middle HERBERT Last PRICE
4. DATE OF DEATH: Month SEPTEMBER Day 29 Year 1967
5. SEX: MALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9/3/1883
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARM OWNER
11. BIRTHPLACE (County & State, or foreign country): ST, MARY,S MARTLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN A. PRICE
14. MOTHER'S MAIDEN NAME: ROSA ~~BLACK~~ ANN WHEATLEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):
16. SOCIAL SECURITY NO.: 215-54-0859J1
17. INFORMANT: MRS. CORINNE MILLER Address: 108 W.39th st. BALTIMORE,MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): Pleuritis — wks
DUE TO (c): Chronic Glomerulonephritis — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
592 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from _____, 19__, to 9/29 1967 that (I) ~~(we)~~ last saw the deceased alive on 9/29 1967, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: Jas P. Jarboe M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 10/1/67
22c. PHYSICIAN'S NAME (Type): J. PATRICK JARBOE M.D.
22d. ADDRESS: GREAT MILLS MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/2/1967
23c. NAME OF CEMETERY OR CREMATORY: HOLY FACE
23d. LOCATION (City or Town) (County) (State): GREAT MILLS ST. MARY,S Md.

24. FUNERAL DIRECTOR: John M. Welch — JOHN M. WELCH — ADDRESS: LEONARDTOWN MARYLAND
25a. REC'D BY REGISTRAR DATE: OCT 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12957 — 12965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXX LEONARDTOWN
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL AVENUE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: HENRY — Last: RAGAN

4. DATE OF DEATH: Month: SEPTEMBER — Day: 23, — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: MARCH 14, 1891

9. AGE (In years last birthday): ~~75~~ 76

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS VIRGINIA R. RALEY — Address: AVENUE, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 13 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/11, 1967, to 9/24, 1967, that (I) (we) last saw the deceased alive on 9/23 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: W. D. Boyd M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): WILLIAM D. BOYD M. D.

22d. ADDRESS: LEONARDTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: ALL SAINTS CEMETERY

23d. LOCATION (City or Town) (County) (State): OAKLEY, ST. MARY'S, MARYLAND

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY — ADDRESS: LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jagge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12958 — 12966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: St,Maryy's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St.Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, ff institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: St.Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dameron
   d. STREET ADDRESS: Apt.#1 Dock's LandingRoad
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Triplet #2 Regina — Middle: (None) — Last: Snyder

4. DATE OF DEATH: Month: September — Day: 21 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-21-1967

9. AGE (In years last birthday): — yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): St. Mary's Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jack Wilfred Snyder

14. MOTHER'S MAIDEN NAME: Jane Muse Stauffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Dameron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity. 4mo — INTERVAL BETWEEN ONSET AND DEATH: 1-2 min

776X

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____M, from the causes and on the date stated above.

22a. SIGNATURE: Ernest D. Rehm M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 25 Sep 67

22c. PHYSICIAN'S NAME (Type): Ernest Rehm M.D.

22d. ADDRESS: Lexington Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: EBENEZER CEMETERY

23d. LOCATION (City, town or county) (State): GREAT MILLS, ST. MARY'S, MD.

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY — ADDRESS: LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Mattingly's

VR A15 (4) 20M f/65

7-252606

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12959 — 12967

1. PLACE OF DEATH
a. COUNTY: St.Mary's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St.Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St.Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dameron
d. STREET ADDRESS: Apt.#1 Dock's Landing Road
e. IS RESIDENCE ON A FARM? YES ☐ ND ☒

18-1

76

3. NAME OF DECEASED (Type or print): First: Triplet #1 Richard — Middle: (None) — Last: Snyder

4. DATE OF DEATH: Month: September — Day: 21 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-21-1967

9. AGE (In years last birthday): — yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): St. Mary's Co. Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jack Wilfred Snyder

14. MOTHER'S MAIDEN NAME: Jane Muse Stauffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Dameron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity - 4 mo — INTERVAL BETWEEN ONSET AND DEATH: 1-2 hr

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ ND ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: Ernest D. Rehm M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 25 Sep 67

22c. PHYSICIAN'S NAME (Type): Ernest Rehm M.D.

22d. ADDRESS: Lexington Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery

23d. LOCATION (City, town or county) (State): Great Mills, St. Mary's, Md.

24. FUNERAL DIRECTOR: Mattingly's — W. Clarke Mattingley — ADDRESS: Leonardtown, Md. Leonardtown, Maryland.

25a. REC'D BY REGISTRAR DATE: SEP 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jenkins

VR A15 (4) 2DM 1/65

7-26262

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12980

CERTIFICATE OF DEATH

12968

1. PLACE OF DEATH
   a. COUNTY: St.Mary's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St.Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: St.Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dameron
   d. STREET ADDRESS: Apt.#1 Dock's Landing Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

18-1

76

3. NAME OF DECEASED (Type or print): First: Triplet #3 — Middle: Robin — Last: (None) Snyder

4. DATE OF DEATH: Month: September — Day: 21 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-21-1967

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): St. Mary's Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jack Wilfred Snyder

14. MOTHER'S MAIDEN NAME: Jane Muse Stauffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Dameron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity - 4 mo — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

776x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____M, from the causes and on the date stated above.

22a. SIGNATURE: Ernest D. Rehm M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 25 Sep 67

22c. PHYSICIAN'S NAME (Type): Ernest Rehm M.D.

22d. ADDRESS: Lexington Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: EBENEZER CEMETERY

23d. LOCATION (City, town or county) (State): GREAT MILLS, ST. MARY'S, MD.

24. FUNERAL DIRECTOR: Mattingly's — ADDRESS: Leonardtown, Md.

W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (A) 20M 1/65

7-252610

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12961 — 12969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. **PLACE OF DEATH**
   a. COUNTY: ST. MARYS — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ST. MARYS NURSING HOME

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ST. MARYS
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: EMMA — Middle: MAY — Last: STEWART

4. **DATE OF DEATH**: Month: SEPT. — Day: 6 — Year: 1967

5. SEX: FEMALE — 6. COLOR OR RACE: WHITE — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 5/10/1882 — 9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE — 10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC — 11. BIRTHPLACE (County & State, or foreign country): NEW YORK — 12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: UNKNOWN — 14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO — 16. SOCIAL SECURITY NO.: 219 56 1162 J1 — 17. INFORMANT: MRS. RUTH STEWART — Address: 521 N. TULARD ST. ARLINGTON, VA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

DUE TO (b): Atherosclerotic CV disease — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Yeer 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/1/ 19 66 to 9/7/ 19 67, that (I) (we) last saw the deceased alive on 9/6 19 67, and that death occurred at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: J. Roy Guyther M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9/7/67

22c. PHYSICIAN'S NAME (Type): J. Roy Guyther — 22d. ADDRESS: MECHANICSVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANSIT — 23b. DATE THEREOF: 9/7/67 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION (City, town or county) (State): SOUTH HILLS-PITTSBURG, PA.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Welch — ADDRESS: JOHN M. WELCH - LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 11 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Gugo

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12962 — 1463

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Mechanicsville
d. STREET ADDRESS: General Delivery
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First — Middle — Last: Stoltzfus
4. DATE OF DEATH: Month: September — Day: 30 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9-30-67
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Samuel S. Stoltzfus
14. MOTHER'S MAIDEN NAME: Lydia S. Hertzler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother — Address: Mechanicsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 5 hours.
7615
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Abruptio placenta
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prematurity - 28 weeks
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from SEPT 29, 1967, to SEPT 30, 1967, that (I) (we) last saw the deceased alive on SEPT 30 1967, and that death occurred at 12:27 AM, from the causes and on the date stated above.

22a. SIGNATURE: William C. Mulford M.D. — M.O. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): William C. Mulford, M.D.
22d. ADDRESS: Mechanicsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 1 1967
23c. NAME OF CEMETERY OR CREMATORY: Stoltzfus Cemetery
23d. LOCATION (City, town or county) (State): Mechanicsville Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardstown, Md.
25a. REC'D BY REGISTRAR DATE: OCT 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

T-252626

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12963

CERTIFICATE OF DEATH

14466

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: 12 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL LEONARDTOWN 18-1
d. STREET ADDRESS: ROUTE 2 BOX 46
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

76

3. NAME OF DECEASED (Type or print): First ELIZABETH — Middle LUCY — Last TIPPETT

4. DATE OF DEATH: Month SEPT. — Day 30, — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: JAN. 26, 1905

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN FRANK MORGAN

14. MOTHER'S MAIDEN NAME: IDA MORGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Address): JOS. RAYMOND TIPPETT — SAME AS # 2 ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): arteriosclerotic heart disease — 10 years
DUE TO
(c):

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes ; Phlebitis, Bleeding peptic ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19 67, to Sept 30 1967, that (I) (we) last saw the deceased alive on Sept 30 1967, and that death occurred at 4 P M, from causes and on the date stated above.

22a. SIGNATURE: Wm D Boyd M.D. — ATTENDING PHYS. ☑ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 10-4-67

22c. PHYSICIAN'S NAME (Type): WILLIAM D BOYD

22d. ADDRESS: LEONARDTOWN Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: OCTOBER 4, 1967

23c. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEMETERY

23d. LOCATION (City or Town) (County) (State): BUSHWOOD, ST. MARY'S, MARYLAND

24. FUNERAL DIRECTOR — **ADDRESS**: W. CLARKE MATTINGLEY — LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: OCT 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

BS 1

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12964

CERTIFICATE OF DEATH

12970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 6 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Rural Leonardtown
d. STREET ADDRESS: Medley's Neck
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Philip — Middle: Francis — Lost: Young
4. DATE OF DEATH: Month: September — Doy: 20, — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: May 8, 1887
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): St. Mary's, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Young
14. MOTHER'S MAIDEN NAME: Martha Lee Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 217-36-6746
17. INFORMANT: Jos. Philip Young — Address: Leonardtown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure
DUE TO (b): Cardio-Vaskular Disease
DUE TO (c):
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse last.
4221
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work [ ] Not While ot work [ ]
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 3/15, 1959 to Sept 20, 1967, that (I) (we) last saw the deceased alive on Sept 27 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Charles Greenwell M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Charles Greenwell M. D.
22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 23, 1967
23c. NAME OF CEMETERY OR CREMATORY: Our Ladys Chapel
23d. LOCATION (City or Town) (County) (Stote): Medlay's Neck, St. Mary's, Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 25 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67